VERMONT
AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

February 13, 2020

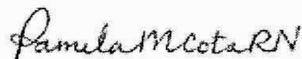
Ms. Dawn Taylor, Manager
Valley Vista
23 Upper Plain
Bradford, VT 05033-9016

Dear Ms. Taylor:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **January 27, 2020.** Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,



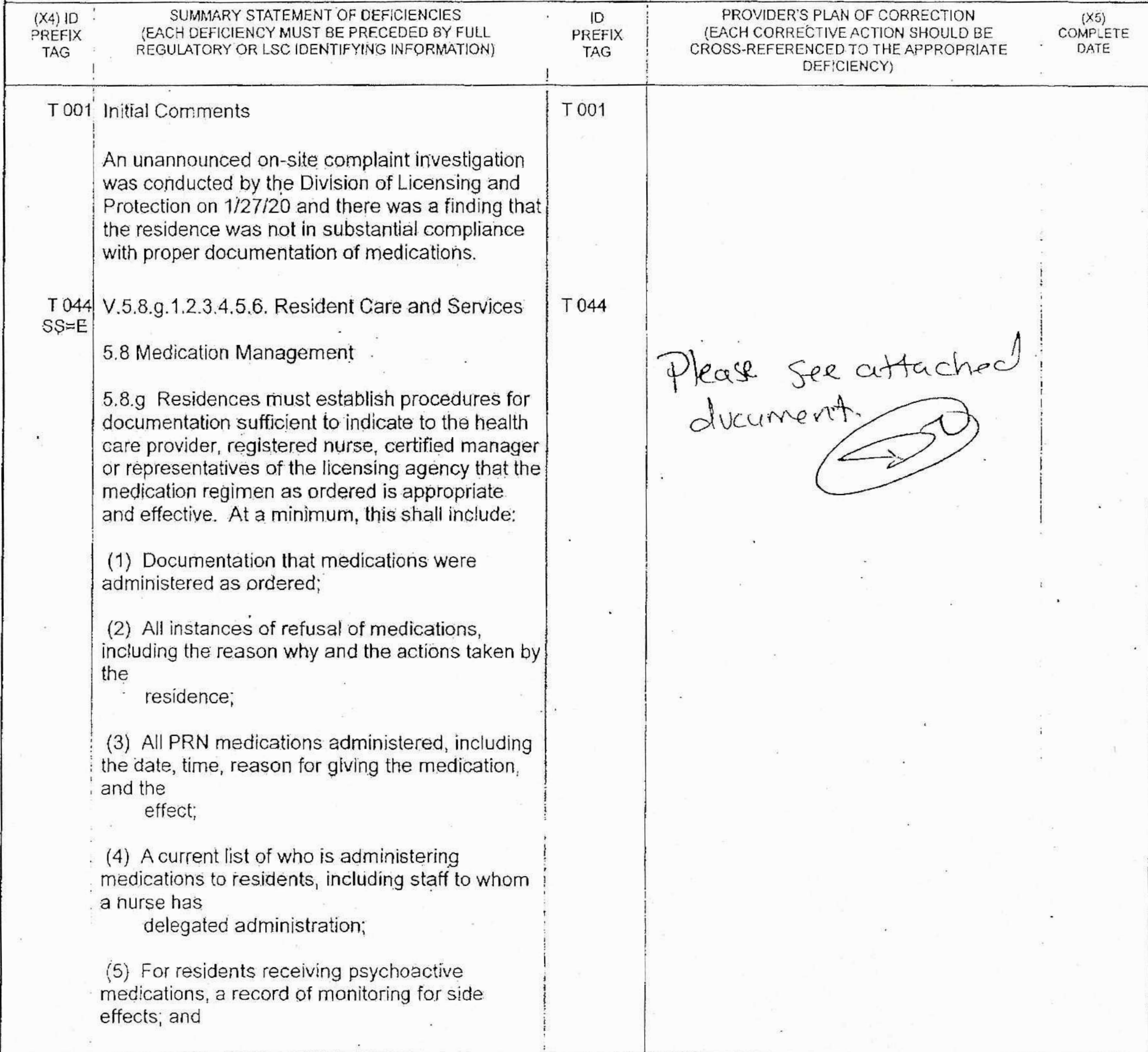
Pamela M. Cota, RN
Licensing Chief

PRINTED: 01/30/2020
FORM APPROVED

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0540	A. BUILDING: ______ B. WING ______	C 01/27/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VISTA	23 UPPER PLAIN BRADFORD, VT 05033



(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 001	Initial Comments An unannounced on-site complaint investigation was conducted by the Division of Licensing and Protection on 1/27/20 and there was a finding that the residence was not in substantial compliance with proper documentation of medications.	T 001		
T 044 SS=E	V.5.8.g.1.2.3.4.5.6. Resident Care and Services 5.8 Medication Management 5.8.g Residences must establish procedures for documentation sufficient to indicate to the health care provider, registered nurse, certified manager or representatives of the licensing agency that the medication regimen as ordered is appropriate and effective. At a minimum, this shall include: (1) Documentation that medications were administered as ordered; (2) All instances of refusal of medications, including the reason why and the actions taken by the residence; (3) All PRN medications administered, including the date, time, reason for giving the medication, and the effect; (4) A current list of who is administering medications to residents, including staff to whom a nurse has delegated administration; (5) For residents receiving psychoactive medications, a record of monitoring for side effects; and	T 044	Please see attached document.	

Division of Licensing and Protection

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Clinical Director (X6) DATE: 2.11.2020

STATE FORM 6899 C6TO11

T044 - POC accepted 2/13/20 BBortell RN/PNM

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T 044	Continued From page 1	T 044		

(6) All incidents of medication errors.

This REQUIREMENT is not met as evidenced by:
Based on staff interview, record review and review of residence policies, the manager failed to insure that all medications were administered as prescribed by the resident physician for 3 of 3 residents, Resident #1, 2 and 3. Findings include:

A review of the Medication Administration Records (MAR) for November 2019 was conducted on 1/27/2020 for the three sampled residents.

1.) Resident #1 did not have complete documentation for the administration of Lyrica (used for Fibromyalgia and seizures) which was ordered to be administered twice a day (BID) on five separate occasions between 11/3/19 and 11/24/19. There is no documentation to indicate the reason it was not signed out or to indicate that it had been given. It was also found that the following medications were not documented as being administered: Wellbutrin (used for depression) twice and his/her Senna (for constipation), which was ordered BID, was only signed as being given six times and no indication as to why it had not been give on the other dates and no indication that the physician had been notified that Resident #1 was refusing the medication. The MAR also had listed PRN (as needed) medications, which per policy needs to be signed when given and the reason documented. Clonidine 0.2 mg (milligram) TID (three times per day) PRN was signed as being given sixteen times between 11/8 and 11/14/19,

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T 044	Continued From page 2 but the reason for it being given was documented only eight times. Benadryl 50 mg every six hours PRN was given twenty times between 11/16 and 11/24/19 with a reason for giving the medication documented only six times. 2.) Resident #2 had an order for Gabapentin 300 mg and Trazodone, there was missing signature for the Gabepentin one time and twice for the Trazodone, and there is no documentation to indicate the reason for holding or not administering. 3.) Resident #3 has orders for Topiramate (anticonvulsant) 25 mg BID ordered 11/19/19 and it was circled 11/19 and 11/20/19, which indicates the medication was not administered and there was no documentation to support the reason it was not given. Propranolol 10 mg TID (three times a day) presents with no signatures on 11/3 and 11/4/19 for 8:00 AM and 2:00 PM. There are no signatures for the 2:00 PM dose on 11/7, 10, 11, 12, 14, 16, 17, 11/21/19. Resident #3 also had an order for Gabapentin 300 mg TID and there are no signatures for 2:00 PM on 11/7, 10, 11, 12, 14, 16, 17, 11/21/19. Also his/her Depakote ER (extended release) was circled six times with no documentation to indicate why the medication was not administered. Confirmation was made the DNS at 11:15 AM that MARs have inaccurate documentation and although controlled medications have been signed out from the control log, the MAR does not indicate the medications have been given at times. Also confirmed there is no documentation to explain why medications were not given and that the nurses responsible for the medication administration didn't complete documentation properly and according to policy.	T 044		

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Ticket	Summary Statement of Deficiencies	Provider's Plan of Correction
T 044	(5.8 g. 1) Documentation that medications were administered as ordered	***Action taken to correct deficiency –*** Staff education through nursing in-service staff meeting on 2/6/20. Daily MAR checks that need to be signed off. ***Measures to be put in place/systemic changes will make to ensure deficient practice does not recur –*** Daily MAR checks that need to be signed off by nursing documenting that they completed the check. (Refer to Appendix A and B) ***How corrective actions will be monitored –*** Documentation sheets will be collected by DNS weekly to ensure systemic change is being implemented. Monthly the DNS or delegate will review a patient chart to ensure that nurses are documenting appropriately and in compliance with the state. ***The dates corrective action will be completed –*** 2/12/20
T044	(5.8 g. 2) All instances of refusal of medications, including the reason why and the actions taken by the residence	***Action taken to correct deficiency –*** Staff education regarding documentation of PRN medications during nursing in-service staff meeting 2/6/20. ***Measures to be put in place/systemic changes will make to ensure deficient practice does not recur –*** Daily MAR checks that need to be signed off by nursing documenting that they completed the check. ***How corrective actions will be monitored –*** Documentation sheets will be collected by DNS weekly to ensure systemic change is being implemented. Monthly the DNS or delegate will review a patient chart to ensure that nurses are documenting appropriately and in compliance with the state. ***The dates corrective action will be completed –*** 2/12/20
T044	(5.8 g. 3) All PRN medications administered, including the date, time, reason for giving the medication, and the effect	***Action taken to correct deficiency –*** Staff education regarding documentation of PRN medications during nursing in-service staff meeting 2/6/20. Example of correct way to document hung in each medication room. ***Measures to be put in place/systemic changes will make to ensure deficient practice does not recur –*** Daily MAR checks that need to be signed off by nursing documenting that they completed the check.

		How corrective actions will be monitored – Documentation sheets will be collected by DNS weekly to ensure systemic change is being implemented. Monthly the DNS or delegate will review a patient chart to ensure that nurses are documenting appropriately and in compliance with the state. ***The dates corrective action will be completed –*** 2/12/20
T044	(5.8 g. 4) A current list of who is administering medications to residents, including staff to whom a nurse has delegated administration	***Action taken to correct deficiency –*** New Master List printed and hung up in Med Rm C for updated signatures reflecting the current prescribing and nursing team. ***Measures to be put in place/systemic changes will make to ensure deficient practice does not recur –*** DNS to monitor Master list monthly and update accordingly ***How corrective actions will be monitored –*** DNS will have new staff added to list and will keep up to date. ***The dates corrective action will be completed –*** 2/12/20
T044	(5.8 g. 5) For residents receiving psychoactive medications, a record of monitoring for side effects	***Action taken to correct deficiency –*** Staff education. If/when a patient is prescribed an antipsychotic medication, an order will also be written to complete an AIMS sheet. ***Measures to be put in place/systemic changes will make to ensure deficient practice does not recur –*** List of psychoactive medications to be displayed in all medication rooms with clear guidelines stating how to fill out AIMS sheet (Refer to Appendix C). Daily MAR checks by nursing to be completed. Patients are also encouraged to report any symptoms they are experiencing and nursing to document under nursing notes and notify MD if applicable. ***How corrective actions will be monitored –*** Daily MAR checks to be completed. Monthly the DNS or delegate will review a patient chart to ensure that nurses are documenting appropriately and in compliance with the state. ***The dates corrective action will be completed –*** 2/12/20
T044	(5.8 g. 6) All incidents of medication errors	***Action taken to correct deficiency –*** Re instating Daily MAR checks to be completed by nursing staff every shift. Visible guidelines for nurses on how to report incidents of medication errors (Refer to Appendix D). DNS or delegate to

		complete Substance Use Preferred Provider: Critical Incident Report Form to be completed and faxed to ADAP within 24 hours of the event. ***Measures to be put in place/systemic changes will make to ensure deficient practice does not recur –*** Daily MAR checks that need to be signed off by nursing documenting that they completed the check. ***How corrective actions will be monitored –*** DNS will be made aware of any instances of medication errors and will provide education to nurse as appropriate. ***The dates corrective action will be completed –*** 2/12/20

APPENDIX A

DAILY MAR CHECKS – Every Shift

Please initial to document that you completed your MAR check during your shift and document anything missing on the appropriate sheet to notify staff that they need to correct it.

	1st Shift	2nd Shift	3rd Shift
Date	1. 2. 3. 4.	1. 2. 3. 4.	1. 2. 3. 4.
Date	1. 2. 3. 4.	1. 2. 3. 4.	1. 2. 3. 4.
Date	1. 2. 3. 4.	1. 2. 3. 4.	1. 2. 3. 4.
Date	1. 2. 3. 4.	1. 2. 3. 4.	1. 2. 3. 4.
Date	1. 2. 3. 4.	1. 2. 3. 4.	1. 2. 3. 4.
Date	1. 2. 3. 4.	1. 2. 3. 4.	1. 2. 3. 4.
Date	1. 2. 3. 4.	1. 2. 3. 4.	1. 2. 3. 4.

APPENDIX B

Please look at your MAR every shift to make sure that you have signed off on all medications (administered and/or not given).

If a patient is refusing a medication you MUST notify MD and document on back of MAR and/or nursing note as to why.

We must fill out an AIMS sheet on anyone who is prescribed an anti-psychotic at least once during their admission.

If you are changing the dose or times of a medication, yellow out the original order and rewrite the order that reflects the physician order.

Patient	Medication	Date/Time	Notes	Initial once corrected	Date Corrected

APPENDIX C

Abnormal Involuntary Movement Scale (AIMS) - Overview

- The AIMS records the occurrence of tardive dyskinesia (TD) in patients receiving neuroleptic medications.
- The AIMS test is used to detect TD and to follow the severity of a patient's TD over time.

Clinical Utility

The AIMS is a 12 item anchored scale that is clinician administered and scored

- Items 1-10 are rated on a 5 point anchored scale.
  - Items 1-4 assess orofacial movements.
  - Items 5-7 deal with extremity and truncal dyskinesia.
  - Items 8-10 deal with global severity as judged by the examiner, and the patient's awareness of the movements and the distress associated with them.
- Items 11-12 are yes-no questions concerning problems with teeth and/or dentures, because such problems can lead to a mistaken diagnosis of dyskinesia.

Examination Procedure

The indirect observation and the AIMS examination procedure are on the following two pages.

Scoring[1]

1. A total score of items 1-7 (Categories I, II, III) can be calculated. These represent observed movements.
2. Item 8 can be used as an overall severity index.
3. Items 9 (incapacitation) and 10 (awareness) provide additional information that may be useful in clinical decision making.
4. Items 11 (dental status) and 12 (dentures) provide information that may be useful in determining lip, jaw and tongue movements.

Psychometric Properties

The AIMS is a global rating method. The AIMS requires the raters to compare the observed movements to the average movement disturbance seen in persons with TD. Such relative judgments may vary among raters with different backgrounds and experience.

1. *Rush JA Jr., Handbook of Psychiatric Measures, American Psychiatric Association, 2000, 166-168.*

AIMS Examination Procedure

Either before or after completing the AIMS on the following page, observe the patient unobtrusively at rest (e.g., in the waiting room).

The chair to be used in this examination should be a hard, firm one without arms.

Questions

1. Ask the patient whether there is anything in his or her mouth (such as gum or candy) and, if so, to remove it.
2. Ask about the *current* condition of the patient's teeth. Ask if he or she wears dentures. Ask whether teeth or dentures bother the patient *now.*
3. Ask whether the patient notices any movements in his or her mouth, face, hands, or feet. If yes, ask the patient to describe them and to indicate to what extent they *currently* bother the patient or interfere with activities.
4. Have the patient sit in chair with hands on knees, legs slightly apart, and feet flat on floor. (Look at the entire body for movements while the patient is in this position.)
5. Ask the patient to sit with hands hanging unsupported -- if male, between his legs, if female and wearing a dress, hanging over her knees. (Observe hands and other body areas).
6. Ask the patient to open his or her mouth. (Observe the tongue at rest within the mouth.) Do this twice.
7. Ask the patient to protrude his or her tongue. (Observe abnormalities of tongue movement.) Do this twice.
8. Ask the patient to tap his or her thumb with each finger as rapidly as possible for 10 to 15 seconds, first with right hand, then with left hand. (Observe facial and leg movements.)
9. Flex and extend the patient's left and right arms, one at a time.
10. Ask the patient to stand up. (Observe the patient in profile. Observe all body areas again, hips included.)
11. Ask the patient to extend both arms out in front, palms down. (Observe trunk, legs, and mouth.)
12. Have the patient walk a few paces, turn, and walk back to the chair. (Observe hands and gait.) Do this twice.

Abnormal Involuntary Movement Scale (AIMS)

Patient Name ______________________ Date of Visit ____________

Code: 0 = None 1 = Minimal 2 = Mild 3 = Moderate 4 = Severe

Movement Ratings: • Rate highest severity observed in category I, II, III. • Rate movements that occur upon activation one point less than those observed spontaneously. • Circle movements as well as code number that applies.		RATER DATE	RATER DATE	RATER DATE	RATER DATE
I FACIAL & ORAL MOVEMENTS	1. **Muscles of Facial Expression** e.g. movements of forehead, eyebrows, periorbital area, cheeks, including frowning, blinking, smiling, grimacing	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
	2. **Lips and Perioral Area** e.g. puckering, pouting, smacking	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
	3. **Jaw** Biting, clenching, chewing, mouth opening , lateral movement	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
	4. **Tongue** Rate only increases in movement both in and out of mouth. NOT inability to sustain movement. Darting in and out of mouth	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
II EXTREMITY MOVEMENTS	5. **Upper (arms, wrists, hands, fingers)** Include choreic movements (i.e. rapid objectively purposeless, irregular, spontaneous) athetoid movements. DO NOT INCLUDE TREMOR (i.e. repetitive, regular, rhythmic)	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
	6. **Lower (legs, knees, ankles, toes)** Lateral knee movement, foot tapping, heel dropping, foot squirming, inversion and eversion of foot	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
III TRUNK MOVEMENTS	7. **Neck, shoulders and hips** Rocking, twisting, squirming, pelvic gyrations	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
IV GLOBAL JUDGEMENT	8. **Severity of abnormal movements overall**	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
	9. **Incapacitation due to abnormal movements**	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
	10. **Patient's awareness of abnormal movements. Rate only patients report:** No Awareness = 0 Aware, no distress = 1 Aware, mild distress = 2 Aware, moderate distress = 3 Aware, severe distress = 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
V DENTAL STATUS	11. Current problems with teeth and/or dentures	YES NO	YES NO	YES NO	YES NO
	12. Are dentures usually worn	YES NO	YES NO	YES NO	YES NO
	13. Endentia?	YES NO	YES NO	YES NO	YES NO
	14. Do movements disappear with sleep?	YES NO	YES NO	YES NO	YES NO

Available for use in the public domain.

Antipsychotics by class

Generic name	Brand names	Chemical class	ATC code	Mechanism of action
		typical antipsychotics		
Acepromazine	Atravet, Acezine	phenothiazine	N05AA04	
Acetophenazine	Tindal	phenothiazine	N05AB07	
Benperidol	Frenactyl	butyrophenone	N05AD07	
Bromperidol	Bromidol, Bromodol	butyrophenone	N05AD06	
Butaperazine	Repoise, Tyrylen	phenothiazine	N05AB09	
Carfenazine		phenothiazine		
Chlorproethazine		phenothiazine	N05AA07	
Chlorpromazine	Largactil, Thorazine	phenothiazine	N05AA01	
Chlorprothixene	Cloxan, Taractan, Truxal	thioxanthene	N05AF03	
Clopenthixol	Sordinol	thioxanthene	N05AF02	
Cyamemazine	Tercian	phenothiazine	N05AA06	
Dixyrazine	Esucos	phenothiazine	N05AB01	
Droperidol	Droleptan, Dridol, Inapsine, Xomolix, Innovar (+ Fentanyl)	phenylbutylamine (butyrophenone)	N05AD08	
Fluanisone		butyrophenone	N05AD09	
Flupentixol	Depixol, Fluanxol	thioxanthene	N05AF01	
Fluphenazine	Prolixin, Modecate	phenothiazine	N05AB02	
Fluspirilene	Redeptin, Imap	diphenylbutylpiperidine	N05AG01	
Haloperidol	Haldol	phenyl-piperidinyl-butyrophenone	N05AD01	
Levomepromazine	Nosinan, Nozinan, Levoprome	phenothiazine	N05AA02	
Lenperone	Elanone-V	butyrophenone		
Loxapine	Loxapac, Loxitane	dibenzoxazepine	N05AH01	
Mesoridazine	Serentil	phenothiazine	N05AC03	
Metitepine		tricyclic dibenzodiazepine		
Molindone	Moban	indole derivative	N05AE02	
Moperone	Luvatren	butyrophenone	N05AD04	
Oxypertine	Equipertine, Forit, Integrin, Lanturil, Lotawin, Opertil	phenylpiperazine	N05AE01	
Oxyprotepine	Moditen (Czech republic)	dibenzothiepine [1]		

Penfluridol	Semap, Micefal, Longoperidol	diphenylbutylpiperidine	N05AG03
Perazine	Taxilan	phenothiazine	N05AB10
Periciazine	Neuleptil, Neulactil	phenothiazine	N05AC01
Perphenazine	Trilafon	phenothiazine	N05AB03
Pimozide	Orap	diphenylbutylpiperidine	N05AG02
Pipamperone	Dipiperon, Dipiperal, Piperonil, Piperonyl, Propitan	butyrophenone	N05AD05
Piperacetazine	Quide	phenothiazine	
Pipotiazine	Piportil	phenothiazine	N05AC04
Prochlorperazine	Compazine, Stemzine, Buccastem, Stemetil, Phenotil	phenothiazine	N05AB04
Promazine	Sparine	phenothiazine	N05AA03
Prothipendyl		phenothiazines	N05AX07
Spiperone	Spiroperidol, Spiropitan	butyrophenone	
Sulforidazine	Imagotan, Psychoson, Inofal	phenothiazine	
Thiopropazate	Artalan, Dartal, Dartalan, Dartan	phenothiazine	N05AB05
Thioproperazine	Majeptil	phenothiazine	N05AB08
Thioridazine	Mellaril, Melleril	phenothiazine	N05AC02
Thiothixene	Navane	thioxanthene	N05AF04
Timiperone		butyrophenone	
Trifluoperazine	Stelazine	phenothiazine	N05AB06
Trifluperidol		butyrophenone	N05AD02
Triflupromazine	Vesprin	phenothiazine	N05AA05
Zuclopenthixol	Clopixol	thioxanthene	N05AF05

atypical antipsychotics

Amoxapine	Asendin, Asendis, Defanyl, Demolox	dibenzoxazepine	N06AA17
Amisulpride	Amazeo, Amipride, Amival, Solian, Soltus, Sulpitac, Sulprix	substituted benzamides	N05AL05
Aripiprazole	Abilify	quinolone	N05AX12
Asenapine	Saphris	dibenzo-oxepino pyrrole	N05AH05
Blonanserin	Lonasen		

Brexpiprazole	Rexulti	quinolone	N05AX16
Cariprazine	Vraylar		N05AX15
Carpipramine	Prazinil, Defekton		
Clocapramine	Clofekton, Padrasen	imidobenzyl	
Clorotepine	Clotepin, Clopiben	tricyclic dibenzodiazepine	
Clotiapine	Entumine		N05AH06
Clozapine	Clozaril	tricyclic dibenzodiazepine	N05AH02
Iloperidone	Fanapt	benzisoxazole	N05AX14
Levosulpiride		benzamide	N05AL07
Lurasidone	Latuda	n-arylpiperazine (piperazine)	N05AE05
Melperone	Bunil, Buronil, Eunerpan	butyrophenone	N05AD03
Mosapramine	Cremin		N05AX10
Nemonapride	Emilace	benzamide	
Olanzapine	Zyprexa, Ozace, Lanzek, Zypadhera	thienobenzodiazepine	N05AH03
Paliperidone	Invega	pyridopyrimidine	N05AX13
Perospirone	Lullan	azapirone	
Quetiapine	Seroquel	dibenzothiazepine	N05AH04
Remoxipride	Roxiam	salicylamide	N05AL04
Reserpine	Raudixin, Serpalan, Serpasil	yohimbine alkaloid	C02AA02
Risperidone	Risperdal, Zepidone	pyridopyrimidine	N05AX08
Sertindole	Serdolect	phenylpyrrole	N05AE03
Sulpiride	Sulpirid, Eglonyl	benzenesulfonamide (benzamide)	N05AL01
Sultopride	Barnetil, Barnotil, Topral	benzamide	N05AL02
Tiapride	Equilium, Tiapridal	benzamide	N05AL03
Veralipride	Agreal, Agradil	benzamide	N05AL06
Ziprasidone	Geodon, Zeldox	n-arylpiperazine (piperazine)	N05AE04
Zotepine	Nipolept	tricyclic dibenzodiazepine	N05AX11

Appendix D

SYSTEM: Care of Patients
SECTION: Medication
SUBJECT: Administration of Medication / Medication Storage / Administration & Disposal

POLICY:
All medications at Valley Vista will be prescribed, dispensed and / or administered according to accepted clinical, local, state and federal statutory practices as outlined in the following guidelines.

1. All medications will be kept in the locked medication room inside of a locked cart or cabinet designated solely for that purpose.
2. Methadone and Suboxone will be kept in the medication safe in the locked Medication Room.
3. Nursing Staff will hold the keys to the medication room and control all access to medications.
4. Medications will be stored in the manner suggested or required by the manufacturer.
5. Out dated drugs will not be stored and, as required by law or the policies of the facility, disposal of drugs will be documented.

Administration of Medication

1. The only persons allowed to administer medication will be those named on the list of staff members authorized to do so by the administration of Valley Vista and the laws of the state of Vermont. The list is posted in the med room and in the administration policy & procedure manual.
2. No client will be allowed to hold any medication, including those dispensed by inhalers, in their room or on their person.
3. All medications administered to a client must be ordered by the Medical Director or his/her appropriately licensed designee. Drugs and prescriptions brought into the facility by a client will not be administered without being personally identified and ordered by the Medical Director or his/her designee. This designee must be appropriately licensed to prescribe or administer medication.
4. All medication errors and adverse drug reactions will be documented on the intranet via the medication error report form and reported to the Medical Director or the physician on duty as soon as discovered.
5. In the event of adverse drug reaction the dispensing pharmacy will be notified by phone and fax.

Staff Resources

1. Staff administering medication will have access to on-line resources for medication information.
2. Staff administering medications will have telephone access to a licensed pharmacist as well as the Medical Director or his/her designee.

A. Important Points to Remember

1. Five 'rights' of medication administration:
    1. Right patient
    2. Right medication

3. Right dose
4. Right route
5. Right frequency/time

2. Be sure patient is correctly identified before giving prescribed medication using photograph and name recognition.

3. Consult prescriber if medication order is not clear, is unusual, or incomplete.

4. Keep medicine room locked at all times.

5. Non-coated tablets may be crushed and dissolved in water when a patient is unable to swallow tablet - - DO NOT crush time release tablets/extended release tablets or crush the pellets of time release capsules. When in doubt, check with the pharmacist.

6. Medicine given to and refused by patients must be disposed of by the nurse.

7. Labels on bottles and vials must always be legible; obtain new labels from pharmacy as needed.

8. All labels must have expiration date of drug.

A. Preparation of Medication: **If an order involves abbreviation of chemical symbols, it shall be filled only if the abbreviations and symbols appear on the approved list.**

1. Have MAR, drinking cups and medication cups on supply in med rooms.
2. Compare order on MAR with labeled directions.
3. Read label a second time.
4. If a medication error is made or noted, the nurse who discovers the error shall:
   a) Immediately notify charge RN/Nurse Manager
   b) Observe patient for ill effects.
   c) **Record error data on intranet**, on medication error form, according to policy.
   d) **Record error on MAR.**

5. Drug Interactions and Reactions:
   a) Any case of drug reaction should be reported immediately to the physician in charge so that appropriate action may be taken for the patient's safety.
   b) Record the drug reaction in the Nursing Notes.
   c) Initiate **Incident Report**, mark Adverse Drug Reaction (ADR) and forward to the Nurse Manager for review.
   d) All patients should be queried during the admission procedure concerning untoward drug reactions and allergies.

C. Administration of Medication

1. Medication shall only be administered by staff members appearing on a list of authorized administrators.
2. Give medication with sufficient amount of water **except with cough syrup.**
3. Remain with patient until you are sure patient has swallowed the medication.
4. Perform mouth checks per protocol on all adolescents and other patients as indicated to decrease risk of diversion.
5. **Cardiac Drugs:**
   a) **Check pulse before giving chronotropic cardiac drugs.**
   b) **DO NOT give drugs such as Digoxin, Digitoxin, Quinidine or beta blockers (clonidine, guanfacine, propranolol) if pulse is below 60 or above 120.**

c) **Pulse rate must be recorded on MAR and if below 60 or above 120, also record pulse in MAR comment section, and the fact that the medication was not given. Any unusual quality of pulse should be described.**

d) **BP will be monitored per MD order or nursing judgement.**

6. DO NOT give oral medication to an unconscious patient.
7. If patient refuses medication, consult charge nurse/Nurse Manager and report to Medical Director or his/her designee.
8. **Medications must always be administered by the individual who has prepared them.**

D. Care of Equipment

1. Discard used medicine cups.
2. Maintain cleanliness.
3. Maintain adequate supplies.

E. Medication Record

1. MAR must be kept up to date.
2. The prescribers order for medication is copied from physician's order sheet into the MAR with date of order and initials of staff transcribing order. Please note and fax order to pharmacy for prescription to be filled. **Indicate if apical pulse is required for cardiac drug.**

F. Recording of Medications

1. **Each person who administers medication must record his/her initials, name, and credentials on medication sheet.**
2. Daily Medications

   a) **Are routinely recorded.**

   b) If for any reason, patients do not receive medication, a notation to this effect and the reason must on the MAR, also notify Medical Director or his/her designee if appropriate.
3. Stat Orders for Medication:

   a) Medication is given immediately after having been ordered by the physician and is not repeated unless another order is written.

   b) Record Stat Order on medication record.
4. PRN Orders for Medications:

   a) Check MAR each time before giving a PRN medication to be certain that order is current.

   b) Record each PRN medication given.

   c) Record response to PRN medication at the end of each shift medication given.

G. Sedatives and narcotics

1. All narcotics and sedatives must be counted by two individuals at the end of each shift, one person who is about to end a period of duty and one who is about to begin a period of duty.
2. The documentation of narcotic counts is kept on file for **at least two years** and then can be discarded. A discrepancy or error must be brought to the attention of the Nurse Manager and Medical Director immediately.
3. All narcotic drugs must be signed out on the log as each dose is given.

The name of the patient, date, time, amount of dose, nurse and number of narcotics left is to be recorded.

4. **When ordering narcotic drugs, prescribers will specify either a length of time, the number of doses to be given, or the order is automatically stopped after 72 hours.**
5. All narcotic and sedative drugs will be crushed with 2 exceptions:
   a. Librium.
   b. Those drugs which the manufacture states should not be crushed.
6. **Methadone and Suboxone, administered to patients at Valley Vista will be accessed from Valley Vista stock medication.**
7. When a patient on Suboxone, who is being discharged from Valley Vista, is not able to obtain an appointment with a Suboxone provider the next day, Valley Vista will order the appropriate amount from Health Direct or patient's home pharmacy, to provide a bridge supply until the next available appointment. These medications will be ordered by prescription, in the patient's name, and billed to the patient's insurer or responsible party.

H. Standard Orders/Protocols

1. Prescribers may, at their discretion, write standard orders to be used on any of their patients when a patient demonstrates the signs and symptoms for which the order is written.
2. These orders are implemented as written.
3. **Protocols also exist for use for routine problems, such as temperature elevation, headache, diarrhea or constipation. Patient must meet inclusion criteria, MUST NOT MEET exclusion criteria, and MUST NOT have allergies to any of the medications.**
4. When given, these drugs must be charted in the medication record and their effects noted.

I. Disposal of Drugs

1. Unused drugs will be disposed in any of the following ways:

a) They may be sealed in an envelope for patient to take home upon discharge. **Only the Medical Director or an appropriately licensed prescriber may dispense medications upon discharge.**

b) They may be returned in the bubble packs to Health Direct—regardless of being full packs or partially-full packs or partially used cards.

c) All medications that were left behind for **more than a month** by patients **as well as any outdated** medications are to be destroyed per facility policy.

d) Controlled substances will be disposed of in the presence of two nurses.

e) all medications destroyed on premises will be disposed of in Deterra bags per facility policy.

J. Samples- CURRENTLY LIMITED TO VIVITROL

a) Samples may be accepted into the facility by a MD or NP/PA. Samples must be logged in designating the name of the drug, lot # and expiration date.

b) Nurses using samples must log out samples designating the name of the drug, and the lot number

c) The night shift will check the samples every three months and discard any samples that are out dated.